

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/15/2012
NAME OF PROVIDER OR SUPPLIER DEARBORN COUNTY HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 600 WILSON CREEK RD LAWRENCEBURG, IN 47025		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for the investigation of a State complaint.</p> <p>Complaint: IN00102535 Unsubstantiated, lack of sufficient evidence.</p> <p>Date of Survey: 05-15-12</p> <p>Facility number: 005077</p> <p>Surveyors: John Lee, R.N. Public Health Nurse Surveyor</p> <p>Dearborn County Hospital is in compliance with 410 IAC 15-1.6-2, Emergency services, Hospital Licensure Rules.</p> <p>QA: cloughlin 06/18/12</p>	S 000		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

ROG311

If continuation sheet 1 of 1